utah department of human services
SUBSTANCE ABUSE AND MENTAL HEALTH

Site Monitoring Report of

Four Corners Community Behavioral Health

Local Authority Contracts #130074 and #130075

Review Dates: October 6th & 19th, 2015

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Section One: Site Monitoring Report

Executive Summary

In accordance with Utah Code Section 62A-15-103, the Division of Substance Abuse and Mental Health (also referred to in this report as DSAMH or the Division) conducted a review of Four Corners Community Behavioral Health (also referred to in this report as FCCBH or the Center) on October 6th & 19th, 2015. The focus of the review was on governance and oversight, fiscal management, pediatric and adult mental health services, substance abuse prevention and treatment services and general operations.

The nature of this examination was to evaluate the Center's compliance with: State policies and procedures incorporated through the contracting process; State mandated mental health services; and Preferred Practice Guidelines. During the examination, the review teams evaluated: the reliability and integrity of the Center's data and its compliance with established programmatic and operational objectives. Additionally, the review included an examination, through sampling, of the Center's efficient and appropriate use of financial resources.

Any program or operational inadequacies are identified in this report as non-compliance issues. The chart on the following page provides a quick reference to locate any non-compliance issues identified by the monitoring team. A detailed description of the issues can be found in the body of this report.

Summary of Findings

Programs Reviewed	Level of Non-Compliance Issues	Number of Findings	Page(s)
Governance and Oversight	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
Child, Youth & Family Mental Health	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	2	9 - 10
Adult Mental Health	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
Substance Abuse Prevention	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
Substance Abuse Treatment	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	3	17 - 21

Governance and Fiscal Oversight

The Division of Substance Abuse and Mental Health (DSAMH) conducted its annual monitoring review at Four Corners Community Behavioral Health (FCCBH). The Governance and Fiscal Oversight section of the review was conducted on October 6th, 2015 by Chad Carter, Auditor IV. Overall cost per client data was analyzed and compared to the statewide Local Authority average. Personnel and subcontractor files were examined for compliance with state licensing laws and adherence to contractual requirements, as well as the Center's own policy. Client fees were reviewed for consistency and adherence to approved fee schedules. Executive travel reimbursements were reviewed to ensure they were appropriate and that no personal benefit has been gained. Detailed service and operating expenditures were examined for proper approval and supporting documentation.

A check was run on the database for both Federal and State Suspension and Debarment. FCCBH was not listed as a suspended or debarred vendor.

The CPA firm Wiggins & Co. P.C. completed an independent audit of San Juan Mental Health/Substance Abuse Special Service District for the year ending June 30, 2015. The auditors issued an unqualified opinion in the Independent Auditor's Report dated September 22, 2015. However, there were three deficiencies discussed in the Management Report:

2015-1 – Lack of Documentation of Control: Policies and procedures for processing of payroll were not followed. Procedures require managers to approve payroll before processing. No approval was noted during testing.

Jeanie Willson, Finance Director, stated that payroll is processed through an electronic time sheet system that was developed by FCCBH. All payroll must be approved by a supervisor, but the system does not print out a report or an audit trail to provide as documentation for the approval. The Center will now send an email each time payroll has been approved, which will be printed out and included in the payroll files.

2015-2 – Purchasing Policy not Adhered: Policy and procedure require Board of Trustee approval for major contracts. Minutes did not indicate the approved contractor for the Aspen Cove contract.

Jeanie stated that the contractor was discussed in the Board meeting when the contract was approved, but that the minutes did not clearly state this. Going forward, they will provide more detail in Board minutes to ensure that the specifics of each approval are documented.

2015–3 – Required Forms W-9 Not Available: Internal Revenue Service requires all recipients of form 1099 to complete and sign a form W-9 or, if not available, backup withholding be withheld from payments to service providers.

Jeanie stated that they will ensure each 1099 recipient completes a W-9 form.

The Division is satisfied with the responses provided by FCCBH for each issue. DSAMH will review the following financial statement audit for resolution to these deficiencies. There were no deficiencies reported in the financial statement audit from the previous year.

Follow-up from Fiscal Year 2015 Audit:

No findings were issued in FY15.

Findings for Fiscal Year 2016 Audit:

FY16 Major Non-compliance Issues:
None

FY16 Significant Non-compliance Issues:
None

FY16 Minor Non-compliance Issues:
None

FY16 Deficiencies:
1) In reviewing the subcontractor files it was noted that they contained all required paperwork, but were missing any written documentation of subcontractor monitoring. The DHS Contract requires that the Local Authorities shall, at a minimum, conduct one annual monitoring review on all subcontractors. Without documentation, it is not possible to know if a Center has been compliant with this requirement. This issue was addressed as a recommendation in the FY15 Monitoring Report. A requirement to utilize a formal subcontractor monitoring tool was added to the FY16 Division Directives, missing monitoring documentation will be treated as a non-compliance issue in future reviews.

FY16 Recommendations:
None

FY16 Division Comments:
None

Mental Health Mandated Services

According to Utah Code 17-43-301, the Local Authority is required to provide the following ten mandated services:
Inpatient Care
Residential Care
Outpatient Care
24-hour Emergency Services
Psychotropic Medication Management
Psychosocial Rehabilitation (including vocational training and skills development)
Case Management
Community Supports (including in-home services, housing, family support services, and respite services)
Consultation and Education Services
Services to persons incarcerated in a county jail or other county correctional facility

The mandate to provide services to those in county correctional facilities is not applicable to the children and youth population.

In subsection (4)(a)(ii) each local authority is required to "annually prepare and submit to the Division a plan approved by the county legislative body for mental health funding and service delivery, either directly by the local mental health authority or by contract." This annual area plan provides the state Division of Substance Abuse and Mental Health with a measuring tool against which the local authority is measured during the annual monitoring site review.

A major focus of the monitoring efforts of the Division of Substance Abuse and Mental Health is to measure compliance with this legislative mandate to provide these services to the adults, youth, and children of Utah.

Child, Youth and Family Mental Health

The Division of Substance Abuse and Mental Health Children, Youth, & Families team conducted its annual monitoring review at Four Corners Community Behavioral Health on October 6th and 19th, 2015. The monitoring team consisted of Eric Tadehara, Program Manager; Dinah Weldon, Program Administrator; and Tracy Johnson, Utah Family Coalition (New Frontiers for Families). The review included the following areas: record reviews, discussions with clinical supervisors and management, case staffing, program visits, allied agency visits, and feedback from families through questionnaires. During the visit, the monitoring team reviewed the FY15 audit; statistics, including the Mental Health Scorecard; Area Plans; Youth Outcome Questionnaires; family involvement; Family Resource Facilitation (Peer Support); Wraparound to fidelity; Multi-Agency Coordinating Committee; school-based behavioral health; Mental Health Early Intervention Funding; civil commitment; compliance with Division Directives; and the Center's provision of the ten mandated services as required by Utah Code 17-43-301.

Follow-up from Fiscal Year 2015 Audit

No findings were issued in FY15.

Findings for Fiscal Year 2016 Audit

FY16 Major Non-compliance Issues:
None

FY16 Significant Non-compliance Issues:
None

FY16 Minor Non-compliance Issues:

1) *Objectives*: During the chart review process, objectives in eight of the twelve charts lacked meaningful, achievable objectives. Sample objectives include the following: client's parents "will report improved behavior," "I [client] don't want to have to be depressed," and the client "will deal with anxiety about change." Each of these objectives fail to show a meaningful way to address the overarching goals, and are difficult to achieve. In three of the charts, objectives were also stagnant over a long period of time, with minimal progress shown in the progress notes or through objective reviews. Division Directives require that short term goals/objectives "are measurable, achievable and within a timeframe".

County's Response and Corrective Action Plan:

Each clinical staff member was provided with an example sheet of well written treatment plans, including Problem Statement, Goal, Objective, and Interventions. In addition, the clinical director went around to each clinic staff meeting to discuss with staff how to develop well

written plans. This will continue throughout the next year. In addition to this, after this past monitoring visit, each program director (overseeing clinical staff) was provided a separate, interactive training on developing well written treatment plans; with a focus on objectives. Another training was recently provided at our annual General Staff meeting, with a breakout focus on clinical staff developing good treatment plans. Program directors have been instructed to bring up one existing or new TX plus plan every week in their staff meeting, and thoroughly go over the plan to develop or enhance plans in a positive way. This will be followed up with by the clinical director during monthly program directors meetings. Quarterly, a set of random TX plus plans will be brought to our program directors meeting and reviewed with program managers. We believe this intensive ongoing training, should resolve most misunderstanding around formulating well written objectives.

2) *Juvenile Civil Commitment:* FCCBH is not using up to date Civil Commitment forms. Civil Commitment Paperwork for juveniles needs to be completed consistent with State statute 62A-15-703 utilizing the proper forms for children's civil commitment procedures located on the DSAMH website at http://dsamh.utah.gov/provider-information/civil-commitment/.

County's Response and Corrective Action Plan:

This concern has already been very well addressed. An extensive training (including Q&A) with Children, Youth, and Family directors (Dinah Weldon, Eric Tadehara) was provided for all FCCBH clinical staff. A number of misunderstandings amongst staff were clarified during that training. Also, all old/outdated Civil Commitment paperwork has been destroyed and a link to the Division website where all new/updated forms are stored will be placed on our Credible home page for easier access. Program directors have developed a separate tracking system for children/youth who maintain a Civil Commitment status. This is reviewed every week at clinic staff meetings. Also, our hospital liaison has been instructed to thoroughly review all paperwork completed on youth being hospitalized within 24 hours of the admission, to ensure accuracy in forms being used.

FY16 Deficiencies:

None

FY16 Recommendations:

1) *Psychosocial Rehabilitation and Respite:* In FY15, FCCBH provided Psychosocial Rehabilitation and Respite services at lower rates than the rural averages. Psychosocial Rehabilitation is being provided at a rate of 2.8%, while the rural average is 15.7%. FCCBH experienced a change in staff personnel which influenced the decrease in rate of Psychosocial Rehabilitation services provided (9.3% in FY14 to 2.8% in FY15). Respite is being provided at a rate of 3.7%, and the rural average is 8.2%. FCCBH makes referrals for Respite services to various local agencies in Carbon and Emery Counties, while providing the majority of their respite in Grand County. FCCBH is encouraged to review the needs and availability of these services and as indicated, seek opportunities to expand services for Psychosocial

Rehabilitation and Respite to further meet the needs of the children and youth in the catchment area.

FY16 Division Comments:

1) *Wraparound and Family Resource Facilitation:* FCCBH provides Wraparound to fidelity as defined by the Utah Family Coalition (UFC). The Family Resource Facilitators (FRFs) are an integral part of service delivery and the services they provide are valued by both families and professional partners. It is recommended that FCCBH look for opportunities to help staff better understand an FRF's role as family voice.

2) *Family Feedback:* Family feedback was provided by 26 families who completed the UFC Family Questionnaire. Families reported FCCBH staff are caring, friendly, and helpful. Twenty of the families reported involvement in their children's treatment planning process, and believe that their input was valued and utilized. Parents also acknowledged, and were grateful for, flexible scheduling and the ease of access for crisis services when needed.

3) *Community Partnerships*: FCCBH is making consistent efforts to partner with agencies throughout the community. For example, FCCBH has provided Mental Health First Aid training to the local Boys and Girls Club. FCCBH also partners with Green River Medical Center, a Federally Qualified Health Center (FQHC), to provide behavioral health and crisis services to local community members through the FQHC.

Adult Mental Health

The Division of Substance Abuse and Mental Health Adult Monitoring Team conducted its annual monitoring review at Four Corners Community Behavioral Health on October 6th and 19th, 2015. The monitoring team consisted of Pam Bennett, Program Administrator, LeAnne Huff, Program Manager, and Michael Newman, Recovery and Resiliency Program Manager. The review included the following areas: record reviews and discussions with clinical supervisors and management teams. During this monitoring visit, records were reviewed from Emery, Carbon and Grand Counties. Visits were conducted at Carbon County Jail, and the New Heights and Interact Clubhouses. Focus groups were held at New Heights and Interact to obtain feedback from program participants. During the discussions, the site visit team reviewed the FY15 Monitoring Report; statistics, including the mental health scorecard; area plans; outcome questionnaires; Division Directives, and the Center's provision of the ten mandated services as required by Utah Code 17-43-301.

Follow-up from Fiscal Year 2015 Audit

FY15 Deficiencies:

1) The Division Directives require that the objectives should be "behavioral changes that are measurable, short term, and tied to the goals."

   This issue has been resolved.

Findings for Fiscal Year 2016 Audit

FY16 Major Non-compliance Issues:

None

FY16 Significant Non-compliance Issues:

None

FY16 Minor Non-compliance Issues:

None

FY16 Deficiencies:

None

FY16 Recommendations:

1) *Outcome Questionnaire (OQ) as an Intervention*: DSAMH recognizes that administration of the OQ at FCCBH exceeds the requirement of 50%. However, Division Directives also require that data from the OQ shall be shared with the client and incorporated into the clinical process, as evidenced in the chart. The use of the OQ as an intervention was evident in only

two out of eight charts reviewed. DSAMH recommends that FCBBH train staff on use and documentation of the OQ.

FY16 Division Comments:

1) *Documentation:* DSAMH notes the emphasis on engagement during initial assessments. Documentation also demonstrates that treatment is strengths-based and recovery-focused, with a holistic approach to wellness.

2) *Mandated Service Delivery:* DSAMH commends FCCBH for increasing jail services and services to the unfunded members of the community. Review of the FY15 Mental Health Scorecard for Adults indicates a doubling of jail services and more than three-fold increase in services to unfunded clients.

3) *New Supported Housing*: FCCBH is commended for working with community partners to open Aspen Cove, a 12 bed apartment building in Moab. This will increase housing options for those who struggle with mental illness and homelessness.

4) *Peer Support*: Peer Support Specialist records were reviewed and technical assistance was provided. Goals specific to peer support were present and notes indicate that recovery, health and wellness are the focus.

5) *Access to Services*: An access test was completed by phone with FCCBH leadership. FCCBH has an open intake process with appointments available the following day. Same day crisis appointments are also available.

6) *Community relationships:* DSAMH commends FCCBH for being an integrated member of the community with a strong networking system, as evidenced by involvement in several community events and local coalitions.

7) *Justice Reinvestment Initiative:* FCCBH has made a concerted effort to engage community partners in the organization and implementation of the Justice Reinvestment Initiative, with representatives from three counties attending multiple meetings and a focus on the promise of recovery.

8) *Staff Retention:* FCCBH has chosen to address staff turnover by removing barriers to their employees. To this end, they are developing affordable staff housing in Moab, an area with very high housing costs.

9) *Integration with Primary Care*: DSAMH recognizes FCCBH's commitment to providing accessible and integrated care to their clients. FCCBH is now co-located with a Federally Qualified Health Center in Green River, Utah.

Substance Abuse Prevention

Susannah Burt, Program Manager, conducted the annual prevention review of Four Corners Community Behavioral Health on October 6th, 2015. The reviews focused on the requirements found in State and Federal law, Division Directives and contracts. In addition, the reviews evaluated the services described in the annual prevention area plan and evaluated the data used to establish prevention priorities.

Follow-up from Fiscal Year 2015 Audit

No findings were issued in FY15.

Findings for Fiscal Year 2016 Audit

FY16 Major Non-compliance Issues:
None

FY16 Significant Non-compliance Issues:
None

FY16 Minor Non-compliance Issues:
None

FY16 Deficiencies:
None

FY16 Recommendations:

1) It is recommended that FCCBH completes a community assessment in at least one community by reviewing data and prioritizing strengths and needs by March 2016.

2) It is recommended that FCCBH implements a strategic plan for the Local Substance Abuse Authority (LSAA) outlining the process used for identifying priority issues and strategies to address the issues by June 2016. This strategic plan will encompass the coalitions within the LSAA.

3) It is recommended that FCCBH continue to encourage training of staff and community members by supporting the attendance at conferences and/or trainings as available.

FY16 Division Comments:

1) Price Police Department completed 18 Eliminating Alcohol Sales to Youth (EASY) checks. Zero alcohol sales to youth occurred. The Emery County Sheriff Department completed 11 EASY checks with 10 establishments not selling. This is an increase in checks from FY14.

2) FCCBH continues to engage prevention into all areas of the agency. Prevention is a part of the directors' meetings. Karen Dolan and Melissa Huntington have been advocates for better prevention in the agency.

3) FCCBH is collaborating with multiple agencies throughout the LSAA. Prevention has worked with these agencies to build readiness to implement prevention strategies. FCCBH's dedication to evidence based processes has increased the capacity and readiness with these communities.

Substance Abuse Treatment

Becky King, Program Administrator and Heather Lewis, Program Manager, conducted the monitoring review on October 6th, 2015. The review focused on: Substance Abuse Treatment (SAPT) block grant compliance; compliance with Division Directives and contracts; drug court program compliance; consumer satisfaction and clinical practices. Compliance with the SAPT block grant, Drug Court, DORA Program and contract requirements were evaluated by a review of policies and procedures; interviews with program managers and client chart audits. Consumer satisfaction and compliance with Division Directives were evaluated using the Division Outcomes Scorecard, the Consumer Satisfaction Scorecard and through face to face interviews with clients.

Follow-up from Fiscal Year 2015 Audit

FY15 Minor Non-compliance issues:

1) Clinical documentation varied significantly from therapist to therapist in FY13 and FY14, which continues to be an issue in FY15.

   This issue has not been resolved and is continued in FY16; see Minor Non-compliance Issue #1.

2) Data from the FY14 Utah Substance Abuse Treatment Outcomes Score Card showed:

   a) The percent of clients retained in treatment 60 or more days decreased from 52.2% to 49.3% from FY13 to FY14 respectively. In FY15, the percent of clients retained in treatment increased to 68.4%, which now meets Division Guidelines.

      This issue has been resolved.

   b) The percentage of clients that completed a treatment episode successfully decreased from 31.3% to 28.1% from FY13 to FY14 respectively. In FY15, the percent of clients completing an episode successfully increased to 48.9%, which now meets Division Guidelines.

      This issue has been resolved.

   c) The percent of tobacco use from admission to discharge increased from 62.9% to 63.0% from FY13 to FY14 respectively. From FY14 to FY15, the percentage of tobacco use from admission to discharge went from -0.2% to -9.2%, which continues to be an issue.

      This issue has not been resolved and is continued in FY16; see Minor Non-compliance Issue #2.

3) FCCBH was not closing cases appropriately. They had 6.4% of "old open admissions" in FY13, which increased to 18.6% in FY14. In FY15, the percent of "old open admissions" decreased to 2.4%, which now meets Division Directives.

This issue has been resolved.

FY15 Deficiencies:

1) FCCBH clinical staff were not scanning and attaching copies of the Risks and Needs Triage (RANT) to the clinical file for Drug Court clients. However, in the FY15, staff started including the RANT in the clinical chart, which now meets Division Directives.

This deficiency has been resolved.

<u>Findings for Fiscal Year 2016 Audit:</u>

FY16 Major Non-compliance issues:
None

FY16 Significant Non-compliance issues:
None

FY16 Minor Non-compliance issues:
1) In FY14 and FY15, there were issues related to clinical documentation, which varied from therapist to therapist. This year, there continues to be clinical documentation issues, but also some noticeable improvements. Many of the issues are related to the adjustment to the new electronic health care record *(Credible)* and staff turnover, which have to be trained on clinical documentation. For this reason, the finding will continue remain as a Minor-Non-compliance issue. The following issues were noted in the chart review this year:

   a) *Treatment Plan*: The objectives in the treatment plan are not specific, time limited or achievable.

   b) *ASAM:* The ASAM form is only showing "low, medium, or high" ratings in each of the dimensions, but is missing the justification for the level of care.

   c) *Group Notes*: Most group notes are not tied to the treatment goals or measuring progress or lack of progress in treatment.

   d) *Discharge Summary*: There is limited information in the Discharge Summary regarding the client's progress in treatment or referral to recovery support services.

      - *The Treatment Plan should have objectives that are specific, time limited and achievable.*

- *The ASAM should include the ratings for each dimension and a justification (brief description) for the level of care.*
- *Group notes should be tied to the treatment goals and measure progress or lack of progress in treatment.*
- *Discharge Summaries should include:*
  - *Recommendations for ongoing services, which include the extent to which established goals and objectives were achieved, what ongoing services are recommended, and description of the individual's recovery status at time of discharge.*
  - *Cultural and Gender Specificity are not clearly documented in most records.*
  - *Referrals and follow-up care provided.*

File Case #'s: 4884, 4551, 4648, 1165, 3108, 4860, 3633, 4730, 3108, 4544, 3348, 4546, and 4105

Center's Response and Corrective Action Plan:

A.) Each clinical staff member was provided with an example sheet of well written treatment plans, including Problem Statement, Goal, Objective, and Interventions. In addition, the clinical director went around to each clinic staff meeting to discuss with staff how to develop well written plans. This will continue throughout the next year. In addition to this, after this past monitoring visit, each program director (overseeing clinical staff) was provided a separate, interactive training on developing well written treatment plans; with a focus on objectives. Another training was recently provided at our annual General Staff meeting, with a breakout focus on clinical staff developing good treatment plans. Program directors have been instructed to bring up one existing or new TX plus plan every week in their staff meeting, and thoroughly go over the plan to develop or enhance plans in a positive way. This will be followed up with by the clinical director during monthly program directors meetings. Quarterly, a set of random TX plus plans will be brought to our program directors meeting and reviewed with program managers. We believe this intensive ongoing training, should resolve most misunderstanding around formulating well written objectives.

B.)When our new Credible system was implemented, an ASAM justification box was simply not added, although our previous EHR system did have one available for staff to complete. Where this has not been a concern in previous monitoring visits, we believe the addition of this justification box was simply an oversight in our Credible development. Thus, a new justification box has been added and staff have once again been asked to complete a justification write up on all clients.

C.)It is our expectation that Group treatment notes will improve, as TX plus plans are improved. Credible allows clinicians to view all goals and objectives when documenting progress. With training around TX plus, we expect clinicians will be developing more useful goals and objectives, allowing a more significant progress update to be tied to those notes. In addition, group treatment notes will be randomly selected quarterly to be reviewed during program directors meeting with each clinic director. This concern will also be made a greater focus during

individual supervision sessions between program directors and clinical staff.

D.)As with the ASAM, when our new Credible system was implemented, a discharge summary portion to the record was simply not added. Our previous EHR system did have one available for staff to complete, and those were being completed upon every client discharge. Where this has not been a concern in previous monitoring visits, we believe the addition of this discharge summary will remedy this concern. In addition, the clinical director and data manager and will go to each clinic providing a training on where the discharge summary will be added in credible and how to complete the summary narrative. Within the narrative, clinical staff will be asked to include the extent to which established goals and objectives were achieved, what ongoing services are recommended, and description of the individual's recovery status at time of discharge, cultural and gender specificity, and referrals and follow-up care.

2) Data from the FY15 Utah Substance Abuse Treatment Outcomes Scorecard shows:

   a) The percent of alcohol use from admission to discharge decreased from 29.6% to 12.4% from FY14 to FY15 respectively.

      Local Substance Abuse Authorities' Outcome Scorecard will show that they increased the percentage of individuals who are Abstinent from Alcohol from admission to discharge in the FY15 at a rate that it greater than or equal to 75% of the National Average. Abstinence from Alcohol is defined as no alcohol use for 30 days.

   b) The percent of individuals that decreased their involvement in criminal activity from admission to discharge decreased from 71.8% to 18.2%.

      Local Substance Abuse Authorities' Outcome Scorecard will show that they decreased the percentage of their individuals who were involved in Criminal Activity from admission to discharge in the FY15 at a rate greater or equal to 75% of the national average. Criminal activity is defined as being arrested within the past 30 days.

   c) The percent of tobacco use from admission to discharge from FY14 to FY15 showed the following outcome: a change from -0.2% to -9.2% respectively.

      Local Substance Abuse Authorities' scorecard will show that the percent of individuals who use tobacco will decrease from admission to discharge.

Center's Response and Corrective Action Plan:

A. After thoroughly investigating the data on this issue, it was found that the lack of improvement in alcohol abstinence from Intake to Discharge is an artifact of the way the data is collected for intake data. Four Corners admission abstinence is very high leaving little for increased abstinence. Prior to admission into Level I or Level II treatment, many Four Corners clients are subject to a controlled environment prohibiting or discouraging them from using

alcohol. When therapists indicate the clients level of use, they were indicating *No Use due to the client being in a controlled environment*. Four Corners has provided, and will continue to provide training to all therapists to ensure when intake data is entered, that they fill it out according the state specification and indicate the use prior to the client being in a controlled environment. Four Corners expects the abstinence at admission to decrease significantly while abstinence at discharge should remain close to the same, thereby drastically increasing abstinence from admission to discharge.

B. Four Corners along with some of the other centers using Credible struggled with Decreased Criminal Involvement due to which field the report pulled the discharge arrests from. As of October, the report began to pull the discharge arrests information from the Client Episode table which is updated each time a client ends a treatment episode. This will result in more accurate reporting of the Criminal Involvement data element.

C. Currently Tobacco Use is reported in Credible's Client Extended table. Therapists do not regularly enter the client extended table as it is primarily data that is entered by the Front office staff. Therefore, the Tobacco Use data element is not updated regularly and does not show improvement from admission to discharge. Four Corners will create a link on the client progress note that will allow the therapist to update the tobacco use data element anytime they complete a progress note. Also, the data manager and clinical director will train staff to update the data element as often as the client changes his/her tobacco use frequency of use or lack thereof. Four Corners provides a very robust tobacco cessation and education program and expects with accurate and timely reporting of this data element, the decrease in tobacco use will show in our data.

3) Data from the FY15 Consumer Satisfaction Surveys shows:

   a) The percent of clients sampled for the Youth Satisfaction Survey *(ages 12-17)* was 2.1%, and the collection rate for Youth Family Satisfaction Survey was 2.0%, which is below the required amount of 10%. It is possible that the change DSAMH made from a paper to electronic system can be attributed to the drop in the collection rate.

      Division Directives state that Local Authority Providers are required to have a survey collection rate of 10% to obtain accurate data results.

Center's Response and Corrective Action Plan:

In past years, Four Corners has monitored the number of surveys completed in total (adult/youth) to ensure at least 10% of clients served complete the survey. This year Four Corners will monitor the number of surveys completed by age category to ensure 10% or more of clients served complete the survey. Additionally, many of the services provided to youth clients, are provided in the schools. Last year (2015) was the first time the consumer satisfaction surveys were administered exclusively electronically. This proved to be a barrier for completing surveys outside of the office setting. Four Corners staff providing services to clients at school will be

provided with paper forms to take to the schools with them and will be transcribed by the front office staff upon return.

FY16 Deficiencies:

None

FY16 Recommendations:

1) *Drug Court:* The FCCBH Team is working on developing a sanctioning matrix. It was noted that the Dependency Drug Court Orientation Manual has not been updated during the past several years, which needs to be addressed. Division Directives state that policies and procedures concerning the administration of sanctions be specified in writing and communicated in advance to Drug Court participants and team members. These policies and procedures provide a clear indication of which behaviors may elicit a sanction; the range of consequences that may be imposed for those behaviors; and the legal collateral consequences that may ensue from graduation and termination.

2) *Engagement:* New clients are spending a considerable amount of time with the intake worker to complete the Assessment. It is recommended that FCCBH consider shortening the intake process so that clients can spend more time with the therapist to complete the assessment, promote engagement and the therapeutic alliance.

FY16 Division Comments:

1) *Quality Services:* FCCBH staff are committed to providing quality services and work tirelessly to impact their community with their services. There is an air of excitement surrounding the Justice Reinvestment Initiative and staff are viewing this initiative as an opportunity for making positive change in their local area.

2) *Housing:* FCCBH has increased housing options for people in the community who might otherwise be unable to secure safe housing, including affordable housing for staff. The use of cost effective housing and sober living in the community has helped many individuals.

3) *Crisis Services*: FCCBH provides crisis services to the community, which includes on-site visits, crisis calls and home visits as needed. A local news article highlighted a police officer's response to a suicide attempt, who was able to assist and redirect the individual through the crisis intervention skills he obtained from the FCCBH Crisis Intervention Team (CIT) Training. The training that FCCBH provides to the community has made a positive impact in their local area.

4) *Program Outcomes:* FCCBH is making efforts to improve program outcomes through the following initiatives:
   - Exemplary Services*(evidence based practice to fidelity with increased supervision)*
   - Good Data *(ongoing quality assurance measures)*
   - Staff Engagement *(low cost housing for staff and wellness plans)*
   - Trauma Informed Care *(Culture Change and building structural changes)*

5) *Direct Access:* FCCBH has an "open access" model, which includes an "intake day" where individuals are served on a "first come first serve" basis. Another part of this model includes "limited treatment services," which are open-ended educational or support groups used as "intern groups" until the client is able to begin treatment or as a recovery support group option. During the "Direct Access" visit with the front desk, it was noted that it was difficult to hear the front desk staff through the glass wall, especially with several people were talking in the waiting room. However, FCCBH is planning to address this issue through building structural changes and trauma-informed methods. FCCBH continues to be a leader in developing innovative and effective services for their community.

Section Two: Report Information

Background

Utah Code Section 62A-15-103 outlines duties of the Division of Substance Abuse and Mental Health. Paragraph (2)(c) states that the Division shall:

- Consult and coordinate with local substance abuse authorities and local mental health authorities regarding programs and services,
- Provide consultation and other assistance to public and private agencies and groups working on substance abuse and mental health issues,
- Receive, distribute, and provide direction over public funds for substance abuse and mental health services,
- Monitor and evaluate programs provided by local substance abuse authorities and mental health authorities,
- Examine expenditures of any local, state and federal funds,
- Monitor the expenditure of public funds by local substance abuse authorities and mental health authorities,
- Contract with local substance abuse authorities and mental health authorities to provide a continuum of services in accordance with division policy, contract provisions, and the local plan,
- Assure that these requirements are met and applied uniformly by local substance abuse authorities and mental health authorities across the state,
- Conduct an annual program audit and review of each local substance abuse authority and mental health authority in the state and its contract provider in a review and determination that public funds allocated to by local substance abuse authorities and mental health authorities are consistent with services rendered and outcomes reported by them or their contract providers,
- Each local substance abuse authority and each mental health authority is exercising sufficient oversight and control over public funds allocated for substance abuse and mental health programs and services, and
- Other items determined by the division to be necessary and appropriate.

Non-Compliance Issues, Action Plans and Timelines

This report is organized into individual sections, in which inadequacies will be identified and discussed. Inadequacies are assigned a level of severity based on the combined judgment of the monitoring team. In order to fully understand the degree of severity, a short discussion of the inadequacy levels follows.

A **major non-compliance issue** is non-compliance in contract requirements which affect the imminent health, safety, or well being of individuals. In cases of non-compliance at this level, a written corrective action plan must be completed by the Local Authority immediately and compliance must be achieved within 24 hours or less.

It should be noted that in extreme cases where, in the professional opinion of the monitoring team, an elevated threat of imminent health, safety, or well being of individuals exists, contract payments may be suspended indefinitely.

A **significant non-compliance issue** is either 1) non-compliance with contract requirements that do not pose an imminent danger to clients but that result in inadequate treatment or care that jeopardizes the well being of individuals; OR 2) non-compliance in required training, paperwork, and/or documentation that are so severe or pervasive as to jeopardize the effectiveness of services and continued contract funding. This type of finding will also require the submission of a written corrective action plan in which the Local Authority identifies the steps it will take to rectify the issue and a time frame for accomplishing the correction. The due date for this submission shall be within **10 working days** of receipt of the draft monitoring report by the Local Authority. Compliance must be achieved within 30 days of receipt of the draft monitoring report. Verification of the resolution may be accomplished in several ways including a follow-up visit, measurement during the next site review, a review of training documentation, a review of data submitted subsequent to the correction or a combination of these or any other method determined adequate to measure the resolution.

A **minor non-compliance issue** results when the reviewers identify a performance inadequacy that is relatively small in scope and does not impact client well being or jeopardize funding. This type of finding will require the submission of a written corrective action plan in which the Local Authority identifies the steps it will take to rectify the issue and a time frame for accomplishing the correction. The due date for this submission shall be within **15 working days** of receipt of the draft monitoring report by the Local Authority. Compliance must be achieved within 60 days of receipt of the draft monitoring report. Verification of the resolution may be accomplished in several ways including a follow-up visit, measurement during the next site review, a review of training documentation, a review of data submitted subsequent to the correction or a combination of these or any other method determined adequate to measure the resolution.

A **deficiency** results when the contractor is not in full compliance, but the deficiency discovered is not severe enough to require a formal action plan. However, the monitoring team may request action to fix the problem by a given date.

A **recommendation** occurs when the contractor is in compliance. The Division is simply making a best practice or technical suggestion. The contractor is encouraged to implement the suggestion but not required.

In rare instances, a non-compliance issue from a previous year may continue unresolved at the time of the monitoring site visit. A recurring non-compliance issue will be prominently displayed in the current monitoring report and will require special attention by the Local Authority to ensure its immediate resolution.

Signature Page

We appreciate the cooperation afforded the Division monitoring teams by the management, staff and other affiliated personnel of Four Corners Community Behavioral Health and for the professional manner in which they participated in this review.

If there are any questions regarding this report please contact Chad Carter at (801)538-4072.

The Division of Substance Abuse and Mental Health

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